

Ex. D

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UNITED STATES DISTRICT COURT

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SOUTHERN DISTRICT OF NEW YORK

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UMAR GUIRA, an infant, by his mother and

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natural guardian ASSETA NANEMA, and ASSETA

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NANEMA, individually,

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Plaintiffs,

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- against -

Index No.:

21-cv-02615-VEC

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UNITED STATES OF AMERICA,

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Defendant.

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March 7, 2022

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1:33 p.m.

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VIRTUAL EXAMINATION BEFORE TRIAL of DR.

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RICHARD LUCIANI, appearing on behalf of the

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Plaintiff herein, taken by the Defendant,

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pursuant to Notice, taken before Nicole L.

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Basile, a Notary Public within and for the

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State of New York.

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2 Mr. Guira's testimony has been more truthful or
3 accurate, correct?

4 A. I believe based on the records and the
5 extent of the injury, as well as the permanence of
6 the injury, that Mr. Guira and Ms. Nanema's
7 recollection of this event is more accurate and is
8 what caused the brachial plexus injury. Not Dr.
9 Bui's recollection of this event.

10 Q. You offer an opinion that there was
11 undiagnosed shoulder dystocia in this case, correct?

12 A. That's correct.

13 Q. What is the basis for that opinion?

14 A. The nature and permanence of the injury
15 of the brachial plexus in this infant, as evidence
16 by the lack of any tumor in the brachial plexus, any
17 signs of infection, any genetic abnormality, any
18 evidence of injury or in malpositioning, which could
19 lead to atrophy of the appropriate limb that was
20 affected. The deposition transcripts of the
21 parties, Mr. Guira and Ms. Nanema, that goes along
22 with the nature of the injury that occurred. So it
23 is the totality of the evidence that has been
24 presented that leads me to this conclusion. I came
25 to this conclusion before the deposition transcripts

1 LUCIANI

2 and once I've read the deposition transcripts, they
3 only further solidify my opinions in this case.

4 Q. So essentially you -- you believe that
5 there are a number of possible causes of Erb's palsy
6 and Erb's palsy injury, and that you can rule out
7 several of them such as tumor, infection, genetic
8 abnormality, malpositioning, et cetera, correct?

9 A. Correct.

10 Q. And you do not believe that natural --
11 that maternal forces of labor can cause an Erb's
12 palsy injury in the absence of shoulder dystocia,
13 correct?

14 A. I do not believe that a permanent Erb's
15 palsy can be caused by maternal forces of labor.
16 The uterus contracts from the fundus down to the
17 pelvis. It is a pushing mechanism that pushes the
18 baby out of the birth canal. There is no traction
19 mechanism. The uterine contracts. And in order to
20 evulse a nerve, or rupture a nerve, you need a
21 traction that pulls the nerve out of the nerve root
22 or pulls the nerve apart. That does not occur with
23 the endogenous forces of maternal labor. The other
24 thing that you have to understand and this is, I
25 believe, very, very important. If you have a patient

1 LUCIANI

2 who is laboring for hours and hours and hours, and
3 this happens hundreds and hundreds and thousands of
4 times daily in the United States, gets to full
5 dilation, pushes for several hours and the doctor
6 says, you know what, this baby is just not gonna
7 come through the pelvis, we're gonna move to a
8 C-section. If the maternal forces of labor were
9 responsible for a brachial plexus injury, then the
10 incidence to a brachial plexus injury should be
11 exactly the same in those cesarean sections, as it
12 would be in the patient who now delivers five to 10
13 minutes later vaginally and that is not the case.
14 It is not the maternal forces of labor that cause
15 it. And anybody that understands the ideology of
16 brachial plexus at the time of cesarean, understands
17 that the mechanism is exactly the same. The head is
18 delivered, the shoulders get caught on the lower
19 uterine segment incision that is not cut large
20 enough to allow an atraumatic delivery of the
21 shoulders. It acts like a pubic synthesis or a
22 sacral hollow and the neck is stretched and the
23 brachial plexus is stretched and you get a shoulder
24 dystocia. Fortunately that is a rare event. It's
25 almost reportable, but yeah, you can get a brachial

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2 plexus injury with a C-section and that's the
3 mechanism. It's not the maternal forces of labor.

4 Q. And you believe that that mechanism
5 accounts for 100 percent of cases of Erb's palsy
6 when in -- I'm sorry. You believe -- yeah. You
7 believe that that mechanism accounts for 100 percent
8 of cases of Erb's palsy with delivery by C-section?

9 A. If you rule out permanent injuries, yes.
10 If you rule out tumor, infection, entry utero
11 malpositioning, genetic abnormalities that could
12 lead to it, yes. That would be the mechanism.

13 Q. Okay. Okay. Let's look at your report
14 and I'm looking at Page 4. You state, "natural
15 labor forces will not result in a permanent brachial
16 plexopathy", correct?

17 A. I do.

18 Q. And then you have a list of five bullet
19 points?

20 A. I do.

21 Q. Okay. I'm going to walk through those.
22 So let's start at bullet point one. You state,
23 "during the prenatal period amniotic fluid fills the
24 amniotic cavity with no part of the fetus subjected
25 to excessive pressure as long as the membranes are

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2 MR. JANIS: Great.

3 Q. Do you see what I have highlighted here?

4 A. I do.

5 Q. I'm sorry. "Significant endogenous
6 forces are generated through natural physical events
7 to move a fetus from the uterus through the birth
8 canal and out of the maternal pelvis." Do you agree
9 with that statement?

10 A. I do.

11 Q. Hold on just one moment.

12 Let's look at Page 24 and I'm looking at
13 the bottom of the first column.

14 MR. JANIS: You need to share
15 it.

16 MR. ISSACHAROFF: I'm sorry.

17 Q. See where it says "for example, uterine
18 contractions result in a compression force to the
19 fetus that acts to move the entire fetus down the
20 birth canal."

21 A. That's a fact.

22 Q. And that's the mechanism that you're
23 describing in bullet point two?

24 A. That's exactly what occurs.

25 Q. And do see you that it goes on to say,

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2 "if, during this movement, a structure obstructs a
3 body" --

4 MR. JANIS: Wait. Wait. Sorry.

5 Can -- can you just -- because you're
6 asking the question and moving the --
7 the document around.

8 MR. ISSACHAROFF: Yeah. Sorry.

9 It spans two columns so I can't really
10 get it on --

11 MR. JANIS: I'm sorry. I didn't
12 realize that. Okay. Go ahead.

13 Q. So the next sentence states "if, during
14 this movement, a structure obstructs a body part
15 while another body segment continues moving forward,
16 the difference in motion can result in either a
17 pulling force on the tissues that connect the two
18 regions or a bending force on a rigid bony body
19 part." Do you agree with that statement?

20 A. I think it's much too general to really
21 comment on. The bottom line is that one body part
22 does not move without the other. Everything is
23 connected. So when you have uterine contractions
24 that are coming from the fundus down and the body is
25 being pushed through the birth canal, one part does

1 LUCIANI

2 not continue moving while the other part does not.
3 So if the shoulder, let's say, gets caught behind
4 the synthesis pubis, that means the head is in front
5 of the synthesis pubis. If the body is continuing
6 to be pushed by the contractions of the uterine
7 fundus and the uterine musculature, everything stops
8 at the pubic synthesis and the head stops moving,
9 because the head does not disconnect. There are no
10 forces of labor that continue to push on the head
11 itself. So the mechanism that you're describing
12 cannot physiologically occur. That's the only thing
13 I would tell you.

14 Q. So you disagree with this portion of the
15 report?

16 A. I do.

17 Q. Okay. But is it fair to say that this
18 portion of the report is causing a mechanism by
19 which traction force can be applied by maternal
20 forces of labor?

21 A. That's still not traction force. That's
22 pressure and pressure is not a traction force.
23 Pressure is a force that can cause some stretching,
24 but it's not gonna -- it's not gonna be a traction
25 force.

1 LUCIANI

2 Q. Do you see it describes here a pulling
3 force or a bending force?

4 A. That's what it says.

5 Q. Is the that not a traction force?

6 A. It depends on, you know, what parts of
7 the body are being affected by that. But that is
8 not a traction force that is going to be significant
9 enough to cause a brachial plexus injury.

10 Q. Okay. Let's go back to your report.
11 And I believe we were talking -- I'm going to look
12 at bullet point three and we were talking about this
13 earlier. You stated essentially that if maternal
14 forces of labor caused brachial plexus injuries, you
15 would expect to see the same rates in C-sections
16 that you see in vaginal deliveries. Is that
17 correct?

18 A. I would expect to see the same rates in
19 C-sections that are done after labor has occurred.
20 The mother has pushed in the second stage and the
21 baby is in the birth canal. I would expect to see
22 the same rate there as I would in a baby that
23 delivers 10 minutes later vaginally. That rate
24 should be exactly the same and it's nowhere near the
25 same.

1 LUCIANI

2 A. Sure. It's called the Zavanelli
3 maneuver. You can push the head right back in.

4 Q. Is that common?

5 A. No. Thank god.

6 Q. So you would expect -- and I'm sorry, do
7 you accept that some NBPP injuries can be caused by
8 the posterior shoulder being caught on the sacral
9 promontory or the hollow of the sacrum?

10 A. The only way a permanent posterior
11 shoulder injury can occur in the absence of
12 infection, cancer, genetic abnormality, injury of
13 malpositioning prior to labor, would be with
14 excessive lateral traction would be utilized. And
15 in that case, it would be pulling the -- the
16 shoulder in an upwards position rather than
17 downwards, which you do in an anterior shoulder.
18 Off axis off the axial line, that's -- that would be
19 the mechanism of the ideology of permanent brachial
20 plexus injury under those circumstances.

21 Q. In the events that the posterior
22 shoulder were caught on the sacral promontory or the
23 hollow of the sacrum, the head would not have
24 delivered, correct?

25 A. Right. But then you would not know

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2 there was posterior shoulder. So dystocia, because
3 that shoulder would have already released if it were
4 on the sacral promontory and the head has now
5 already come out. So there would be no posterior
6 shoulder dystocia in that case. So that wouldn't
7 even apply to the definition of a shoulder dystocia.

8 Q. But you can have NBPP without shoulder
9 dystocia, correct?

10 A. Under the conditions that I have
11 discussed, yes.

12 Q. If the -- in the event that the
13 posterior shoulder were caught on the sacral
14 promontory or the hollow of the sacrum, the head --
15 the head would not have delivered, correct?

16 A. It would be hard to imagine that a
17 shoulder that is caught on the sacral promontory,
18 the head can deliver, because that distance wouldn't
19 be covered. There is too much distance between the
20 sacral promontory and the vaginal outlet for the
21 head to have already come out. If the shoulder is
22 down in the maternal pelvis and is in the hollow of
23 the sacrum, and gets caught on the hollow of the
24 sacrum and soft tissue, then the head can already
25 deliver under those circumstances.

1 LUCIANI

2 Q. If the head has not delivered, is it
3 possible to perform maneuvers on the head without
4 the use of forceps or vacuum?

5 A. Well, if the head is not delivered, then
6 there would be no documentation of shoulder
7 dystocia. That would be the first answer to the
8 question. And the second thing is that if the head
9 is not delivering, the doctor chooses to utilize
10 forceps or a vacuum, those would be the indications
11 to utilize them to assist the head in delivering.

12 Q. Right. But if the head has not
13 delivered, there is no way to perform maneuvers on
14 the head without the use of tools, correct?

15 A. What kind of -- well, you can -- you can
16 rotate the head while it's still in utero by just
17 rotating it by putting your hand on it and rotating
18 it. Doctors rotate the head from an oxford
19 posterior to an oxford anterior sometimes and the
20 body goes along with it. I mean, that -- that --
21 those are techniques that have been utilized --
22 rotation maneuvers by the doctor.

23 Q. Okay. Are you aware of any statistics
24 that look at the rate of NBPP in laboring C-sections
25 as a thing from non-laboring C-sections?

1 LUCIANI

2 A. I have not. I don't see articles
3 published like that, but certainly there should be.
4 And one would realize that the instance of NBPP
5 should be exactly the same in laboring C-sections,
6 as it was in vaginal deliveries, if the maternal
7 forces of labor were responsible for the permanent
8 brachial plexus injury.

9 Q. Is it possible that there could be
10 multiple mechanisms of brachial plexus injuries and
11 that some of those would be attributable to the
12 later stages of vaginal delivery?

13 A. Not the way I described it to you.

14 Q. Okay. Let's look at bullet point four
15 of your report. You state that, "the use of vacuums
16 and forceps greatly increase the risk of brachial
17 plexus" injury and that "this could not be the case
18 if a high proportion of these injuries were
19 unrelated to vaginal birth."

20 A. Right. Correct.

21 Q. Were vacuums or forceps used in this
22 case?

23 A. Not to my knowledge.

24 Q. Are you aware of any evidence in the
25 medical records or in anyone's testimony, that there

1 LUCIANI

2 was essentially a significant manipulation of the
3 fetus before it entered the birth canal in the way
4 that you were just describing?

5 A. No.

6 Q. Let's look at bullet point five. You
7 state, "according to ACOG brachial plexus literature
8 transient injuries have been attributed to the labor
9 process however permanent injuries have not been
10 attributed to these maternal forces." When you talk
11 about the ACOG brachial plexus literature, are you
12 talking about the report that we've been looking at?

13 A. Certainly one of the ACOG publications
14 is that report.

15 Q. Do you have any other specific ACOG
16 literature in mind, other than the report that we've
17 been looking at?

18 A. Well, the, you know, the -- the American
19 College has published other things. Practice
20 bulletins have been published, documents that
21 obviously discuss shoulder dystocia and brachial
22 plexus palsy. So that's -- that's part of what I
23 have referred to.

24 Q. So is it fair to say that you see a
25 distinction between transient and persistent

1 LUCIANI

2 brachial plexus injuries?

3 A. I do.

4 Q. And it's your opinion that persistent
5 brachial plexus injuries, as opposed to transient
6 injuries, imply the application of excessive force
7 by the birth attendant?

8 A. If the injury cannot be attributed to
9 other causes, which we've gone over in detail, than
10 the only mechanism of injury that would cause the
11 permanent brachial plexus injury would be a use of
12 excessive lateral traction off the axial line by the
13 delivering physician.

14 Q. Let's look back at Exhibit 3 and now I'm
15 gonna go to page 28.

16 Okay. I'm looking at the first sentence
17 of the second paragraph of the second column. I'll
18 zoom in here. Do you see where it says, "no
19 published clinical or experimental data exist to
20 support the contention that the presence of
21 persistent (as compared to transient) NBPP implies
22 the application of excessive force by the birth
23 attendant."?

24 A. That's what it says.

25 Q. Is that constant with the opinion you've

1 LUCIANI

2 offered in bullet point five of your report?

3 A. There is nothing in the ACOG literature
4 including that statement, that says that persistent
5 brachial plexus injuries can definitely occur as a
6 result of the process of the maternal forces of
7 labor. You show me that statement anywhere. It
8 does not state that. If you go to the beginning of
9 the task force of literature, it clearly states that
10 transient injuries have been related to maternal
11 forces of labor. So if they're willing to say that,
12 then why aren't they willing to say that persistent
13 injuries can definitely result from maternal forces
14 of labor. All right. Evulsions and/or ruptures.
15 You see that anywhere in that article, because I
16 don't see it.

17 Q. But the report does say that there is no
18 published clinical or experimental data to support
19 -- drawing the distinction between transient and
20 persistent brachial plexus injuries, in terms of
21 attributing the cause to the application of
22 excessive force by the birth attendant, correct?

23 A. Well, that's what the report says. I
24 cannot disagree with that.

25 Q. Okay. So now you were talking about --

1 LUCIANI

2 30 minutes after the time of delivery, correct?

3 A. Yes.

4 Q. Okay. And do you see the penultimate
5 field here, it says, "shoulder dystocia: No?

6 A. I do see that. So that was obviously in
7 the delivery record. I stand corrected.

8 Q. So based on this, it's fair to say that
9 there was not -- Dr. Bui did not diagnose a shoulder
10 dystocia and then forget to document it, correct?

11 A. No. She does not recognize a shoulder
12 dystocia.

13 Q. Okay. Does that change your view of the
14 likelihood of an undiagnosed shoulder dystocia at
15 all?

16 A. Not at all. She did not diagnose the
17 shoulder dystocia, which was the source of the
18 injury in this case with the utilization of
19 excessive lateral traction.

20 Q. Okay. Have you formed any other
21 opinions in this case, that we have not discussed
22 today?

23 A. You're a nice guy.

24 Q. Thank you.

25 Anything other than that?